

Bureau of Health Care Quality and Compliance

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS4576HOS | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/06/2010 |
| NAME OF PROVIDER OR SUPPLIER SAINT ROSE DOMINICAN HOSPITAL - SAN MARTIN C | | STREET ADDRESS, CITY, STATE, ZIP CODE 8280 W WARM SPRINGS ROAD LAS VEGAS, NV 89113 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| S 000 | <p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 6/16/2010 and finalized on 8/6/2010, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.</p> <p>Complaint #NV00025587 was substantiated with deficiencies cited. (See Tag S0325) Complaint #NV00025634 was unsubstantiated. Complaint #NV00025504 was unsubstantiated. Complaint #NV00025505 was unsubstantiated</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> | S 000 | | |
| S 325 SS=D | <p>NAC 449.3628 Physical Restraint Use</p> <p>5. The governing body shall ensure that the use of any physical restraints on a patient is initiated only pursuant to a physician's order or protocols approved by the medical staff and the hospital administration.</p> <p>This Regulation is not met as evidenced by: Based on interview, record review and document</p> | S 325 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| S 325 | Continued From page 1 review, the facility failed to follow their policy on obtaining physician's orders for physical restraints for Patient #2. Severity: 2 Scope: 1 | S 325 | | | |

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